Complete Summary

GUIDELINE TITLE

Prophylactic oophorectomy.

BIBLIOGRAPHIC SOURCE(S)

American College of Obstetricians and Gynecologists (ACOG). Prophylactic oophorectomy. Washington (DC): American College of Obstetricians and Gynecologists (ACOG); 1999 Sep. 7 p. (ACOG practice bulletin; no. 7). [33 references]

GUIDELINE STATUS

This is the current release of the guideline.

According to the guideline developer, this guideline is still considered to be current as of December 2004, based on a review of literature published that is performed every 18-24 months following the original guideline publication.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

High risk of developing ovarian cancer

GUIDELINE CATEGORY

Counseling
Evaluation
Prevention
Risk Assessment

CLINICAL SPECIALTY

Medical Genetics
Obstetrics and Gynecology
Oncology
Preventive Medicine
Surgery

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

- To aid practitioners in making decisions about appropriate obstetric and gynecologic care
- To weigh the risks and benefits of prophylactic oophorectomy and provide a framework for the evaluation and counseling of patients who would be candidates for this procedure

TARGET POPULATION

Women at high risk of developing ovarian cancer

INTERVENTIONS AND PRACTICES CONSIDERED

1. Prophylactic oophorectomy
2. Hormone replacement therapy

MAJOR OUTCOMES CONSIDERED

- Risk factors for ovarian cancer including genetic factors
- Operative risks at the time of hysterectomy

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The MEDLINE database, the Cochrane Library, and American College of Obstetricians and Gynecologists' (ACOG's) own internal resources and documents were used to conduct a literature search to locate relevant articles published between January 1985 and January 1999. The search was restricted to articles published in the English language. Priority was given to the articles reporting results of original research although review articles and commentaries also were

consulted. Abstracts of research presented at symposiums and scientific conferences were not considered adequate for inclusion in this document.

Guidelines published by organizations or institutions such as the National Institutes of Health and ACOG were reviewed, and additional studies were located by reviewing bibliographies of identified articles.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force.

I Evidence obtained from at least one properly designed randomized controlled trial

II-1 Evidence obtained from well-designed controlled trials without randomization

II-2 Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group

II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence

III Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Analysis of available evidence was given priority in formulating recommendations. When reliable research was not available, expert opinions from obstetrician-gynecologists were used. See also the "Rating Scheme for the Strength of Recommendations" field regarding Grade C recommendations.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Levels of Recommendations

A. The recommendation is based on good and consistent scientific evidence.
B. The recommendation is based on limited or inconsistent scientific evidence.
C. The recommendation is based primarily on consensus and expert opinion.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Practice Bulletins are validated by two internal clinical review panels composed of practicing obstetrician-gynecologists generalists and sub-specialists. The final guidelines are also reviewed and approved by the American College of Obstetricians and Gynecologists (ACOG) Executive Board.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The grades of evidence (I-III) and levels of recommendations (A-C) are defined at the end of "Major Recommendations" field.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- The decision to perform prophylactic oophorectomy should not be based only on age; it should be a highly individualized decision that takes into account several patient factors and choices.
- Removal of one ovary at the time of hysterectomy in premenopausal women may indicate the suspicion of clinical disease. The likelihood of future pathology in the retained ovary is therefore greater. The patient should be counseled before surgery that if ovarian pathology is found, bilateral oophorectomy may be indicated.

- Hormone replacement therapy should be considered for women undergoing prophylactic oophorectomy, and patients should be counseled about the risks and benefits of hormone replacement therapy prior to undergoing surgery.
- Compliance with hormone replacement therapy is important in women undergoing prophylactic oophorectomy to reduce the risk of future morbidity.
- Prophylactic oophorectomy should be considered for select women at high risk of inherited ovarian cancer.
- In addition to health risks and benefits, patient counseling should include consideration of how oophorectomy may relate to the individual patient's body image, perceptions concerning sexuality, and personal feelings.

Definitions:

Grades of Evidence

I Evidence obtained from at least one properly designed randomized controlled trial

II-1 Evidence obtained from well-designed controlled trials without randomization

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II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments could also be regarded as this type of evidence.

III Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

Levels of Recommendations

A. The recommendation is based on good and consistent scientific evidence.
B. The recommendation is based on limited or inconsistent scientific evidence.
C. The recommendation is based primarily on consensus and expert opinion.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Prophylactic Oophorectomy

- Prevention of ovarian cancer
- Alleviation of symptoms related to ovarian function, especially in patients with documented premenstrual syndrome

Hormone Replacement Therapy

- Favorable effect on bone metabolism
- Lowering levels of lipoprotein A, cholesterol, and other hemostatic factors
- Beneficial effects on cardiovascular hemodynamics and cardiovascular disease

POTENTIAL HARMS

The morbidity associated with prophylactic oophorectomy is primarily related to the loss of estrogen. Patients who do not take hormone replacement therapy after oophorectomy will experience symptoms of early menopause, such as vasomotor hot flashes and vaginal atrophy, and are at a higher risk for osteoporosis.

QUALIFYING STATEMENTS

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These guidelines should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1999 Sep (reviewed 2004)

GUIDELINE DEVELOPER(S)

American College of Obstetricians and Gynecologists - Medical Specialty Society

SOURCE(S) OF FUNDING

American College of Obstetricians and Gynecologists (ACOG)

GUIDELINE COMMITTEE

American College of Obstetricians and Gynecologists (ACOG) Committee on Practice Bulletins-Obstetrics

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

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GUIDELINE AVAILABILITY

Electronic copies: Not available at this time.

Print copies: Available for purchase from the American College of Obstetricians and Gynecologists (ACOG) Distribution Center, PO Box 4500, Kearneysville, WV 25430-4500; telephone, 800-762-2264, ext. 192; e-mail: sales@acog.org. The ACOG Bookstore is available online at the ACOG Web site.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

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